WEST VIRGINIA CODE: §5-16-9

§5-16-9. Authorization to execute contracts.

(a) The director is given exclusive authorization to execute such contract or contracts as are necessary to carry out the provisions of this article.

(b) The provisions of §5A-3-1 *et seq*. of this code, relating to the Division of Purchasing of the Department of Finance and Administration, shall not apply to any contracts for any insurance coverage or professional services authorized to be executed under the provisions of this article. Before entering into any contract for any insurance coverage, as authorized in this article, the director shall invite competent bids from all qualified and licensed insurance companies or carriers that may wish to offer plans for the insurance coverage desired. The director shall negotiate and contract directly with health care providers and other entities, organizations, and vendors in order to secure competitive premiums, prices, and other financial advantages. The director shall deal directly with insurers or health care providers and other entities, organizations, and vendors in presenting specifications and receiving quotations for bid purposes. No commission or finder's fee, or any combination thereof, shall be paid to any individual or agent: *Provided*, That this shall not preclude an underwriting insurance company or companies, at their own expense, from appointing a licensed resident agent within this state to service the companies' contracts awarded under the provisions of this article. Commissions reasonably related to actual service rendered for the agent or agents may be paid by the underwriting company or companies. In no event shall payment be made to any agent or agents when no actual services are rendered or performed. The director shall award the contract or contracts on a competitive basis. In awarding the contract or contracts, the director shall consider the experience of the offering agency, corporation, insurance company, or service organization in the group hospital and surgical insurance field, group major medical insurance field, group prescription drug field, and group life and accidental death insurance field, and its facilities for the handling of claims. In evaluating these factors, the director may employ the services of impartial, professional insurance analysts or actuaries, or both. Any contract executed by the director with a selected carrier shall be a contract to govern all eligible employees subject to the provisions of this article. Nothing contained in this article shall prohibit any insurance carrier from soliciting employees covered hereunder to purchase additional hospital and surgical, major medical, or life and accidental death insurance coverage.

(c) The director may authorize the carrier with whom a primary contract is executed to reinsure portions of the contract with other carriers which elect to be a reinsurer and who are legally qualified to enter into a reinsurance agreement under the laws of this state.

(d) Each employee who is covered under any contract or contracts shall receive a statement of benefits to which the employee, his or her spouse, and his or her dependents are entitled under the contract, setting forth the information as to whom the benefits are payable, to whom claims shall be submitted, and a summary of the provisions of the contract or

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contracts as they affect the employee, his or her spouse, and his or her dependents.

(e) The director may at the end of any contract period discontinue any contract or contracts it has executed with any carrier and replace the same with a contract or contracts with any other carrier or carriers meeting the requirements of this article.

(f) The director shall include language in all contracts for pharmacy benefits management, as defined by §33-51-3 of this code, requiring the pharmacy benefit manager to report quarterly to the agency the following:

(1) The overall total amount charged to the agency for all claims processed by the pharmacy benefit manager during the quarter;

(2) The overall total amount of reimbursements paid to pharmacy providers during the quarter;

(3) The overall total number of claims in which the pharmacy benefits manager reimbursed a pharmacy provider for less than the amount charged to the agency for all claims processed by the pharmacy benefit manager during the quarter; and

(4) For all pharmacy claims, the total amount paid to the pharmacy provider per claim, including, but not limited to, the following:

(A) The cost of drug reimbursement;

(B) Dispensing fees;

(C) Copayments;

(D) The amount charged to the agency for each claim by the pharmacy benefit manager;

(E) Date of service;

(F) NDC-11;

(G) Drug name;

(H) Drug strength;

(I) Quantity;

(J) Days of therapy;

(K) Rx count;

(L) Mail/retail code;

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(M) Brand/generic indicator;

(N) Specialty drug indicator;

(O) Compound indicator;

(P) Formulary indicator;

(Q) Gross cost;

(R) Member cost;

(S) Plan cost;

(T) Dispense as written;

(U) Pharmacy NPI number;

(V) Pharmacy Claim ID;

(W) Prescriber NPI number;

(X) Pharmacy name; and

(Y) Ingredient cost.

In the event there is a difference between the amount for any pharmacy claim paid to the pharmacy provider and the amount reimbursed to the agency, the pharmacy benefit manager shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. The director shall provide an annual report to the Joint Committee on Health detailing the information required by this section, including any difference or spread between the overall amount paid by pharmacy benefit managers to the pharmacy providers and the overall amount charged to the agency for each claim by the pharmacy benefit manager. To the extent necessary, the director shall use aggregated, nonproprietary data only: *Provided*, That the director must provide a clear and concise summary of the total amounts charged to the agency and reimbursed to pharmacy providers on an annual basis.

(g) If the information required herein is not provided, the agency may terminate the contract with the pharmacy benefit manager and the Office of the Insurance Commissioner shall discipline the pharmacy benefit manager as provided in §33-51-8(e) of this code.

(h) The Public Employees Insurance Agency shall contract with networks to provide care to its members out of state.

(i) The Public Employees Insurance Agency shall require each of the following in its requests for proposals and contracts with a pharmacy benefit manager:

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(1) The pharmacy benefit manager shall disclose all information and data related to contracting, reimbursement, networks, rebates, fees, and any other information and data requested by the Public Employees Insurance Agency, the Legislature, and vendors for the purpose of performing study and analysis.

(2) A pharmacy benefit manager shall not reimburse a West Virginia pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost for a prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee at least equal to the professional dispensing fee paid by West Virginia Medicaid for outpatient drugs. Increases to the professional dispensing fee may be set by the director in accordance with this subdivision: *Provided*, That if the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy benefit manager may not reimburse a West Virginia pharmacy or pharmacist in an amount that is less than the wholesale acquisition cost of the drug, as defined in 42 U.S.C. § 1395w-3a(c)(6)(B), plus a dispensing fee as described in this subdivision. A West Virginia pharmacy is a domestic business entity as registered with the West Virginia Secretary of State. The provisions in this subdivision shall be effective for the Public Employees Insurance Agency plan year beginning on July 1, 2024.

(j) Any contract with the Public Employees Insurance Agency for pharmacy benefits management services with a pharmacy benefit manager is subject to the requirements of §33-51-1 *et seq*. of this code and the jurisdiction of the Office of the Insurance Commissioner: *Provided*, That the Public Employees Insurance Agency is not subject to §33-51-9(e) of this code, and nothing in this subsection shall be applied to conflict with Medicare.

(k) By July 1, 2026, the Public Employees Insurance Agency shall issue a competitive bid solicitation for a contract with a pharmacy cost containment vendor actively engaging prescribing providers by presenting information regarding cost and effectiveness, including but not limited to data related to lowest net cost pharmaceutical decisions and related to reductions to polypharmacy rates, if clinically reviewed and appropriate.

(1) The vendor managing this service shall be separate and distinct from any pharmacy benefit management contract that any state agency may have in the management of the pharmacy benefit.

(2) The vendor shall work with the Public Employees Insurance Agency to ensure that the lowest net cost outcome is achieved, including calculation of drug manufacturer rebates and other considerations that may be offered to the state, while not negatively impacting patient outcomes.

(3) Prescribing providers engaged by the vendor are not required to modify their prescribing based on the information presented pursuant to this subsection but the agency retains discretion to modify its drug formulary based on the vendor's recommendations.

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(4) The pharmacy cost containment vendor contract shall contain provisions guaranteeing the state an itemized monthly activity and savings report and a total net savings guarantee related to all expenditures and fees for the pharmacy cost containment service.

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